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	157249	A. BUILDING _____ B. WING _____	12/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSOCIATED HOMECARE INC	2255 STURDY RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal home health recertification survey. This was an extended survey. Survey dates: 12/18/12 - 12/21/12 Facility: 006155 Medicaid #: 100265980A Surveyor: Ingrid Miller, RN, PHNS Skilled unduplicated census: 40 patients Associated Homecare, Inc. is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 01/02/2013 to 01/02/2015 due to being found out of compliance with the Conditions of Participation 42 CFR 484.30 Skilled Nursing Services and 484.36 Home Health Aide Services. Quality Review: Joyce Elder, MSN, BSN, RN January 2, 2013 This survey was modified as the result of an IDR 1/28/13. je	G 000		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on home visit observation, interview,	G 101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 101	Continued From page 1 clinical record review, and agency document review, the agency failed to ensure the patient's right to be treated with dignity were honored for 1 of 3 home visit observations (patient #1) with a home health aide present with the potential to affect all patients receiving home health aide services. Findings 1. On 12/18/12 at 8:15 PM at a home visit observation, Employee E, Home Health Aide, was observed to give a partial bed bath to Patient #1. During the bath, Employee E failed to cover Patient #1 with a bath blanket as the bath was completed. The patient was undressed and exposed with no bath blanket or other covering for 6 minutes, not allowing the patient dignity. 2. Clinical record #1, start of care 11/16/09, evidenced a document titled "Patient / Client Bill of Rights" and signed by the patient on 11/16/09 that stated, "The patient has the right to be treated with dignity." 3. The agency policy titled "Patient / Client Bill of Rights" with a review date of 3/29/12 stated, "The patient has the right to be treated with dignity." 4. On 12/18/12 at 9:30 PM, Employee B, the alternate administrator, indicated Employee E did not drape patient #1 for dignity during the partial bath.	G 101		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply	G 121		

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G 121	Continued From page 2 to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on home visit observation, interview, and policy review, the agency failed to ensure all employees followed agency policies related to infection control for 2 of 5 (patient #1 and #4) home visit observations resulting in the potential to spread infectious diseases to other patients, family, and staff. Findings 1. On December 18, 2012, at 8:15 PM, Employee E , Home Health Aide, was observed to wash her hands before starting care for patient #1 by turning on the water with her hands at the kitchen sink. She used her hands, not a paper towel, to turn on the faucets. After wetting her hands with the running water, she used the patient's dish soap to apply soap to her hands and then she rubbed her hands for 15 seconds with the dish soap and water. She did not wash her wrists. After rinsing, she turned off the faucet with her washed hands and then used the patient's soiled dish cloth to dry her hands before caring for the patient. a. On 12/20/12 at 4 PM, the administrator indicated Employee E did not follow the agency's policies and procedures for handwashing. b. The agency policy titled "Handwashing" with a review date of 3/29/12 stated, "Turn the faucet on with a paper towel held between your hands and the faucet ... Discard the paper towel	G 121		

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G 121	Continued From page 3 ... completely wet your hands and wrists under the running water ... Apply soap. Work up a good lather. Spread it over the entire area of your hands and wrists ... Use a rotating and rubbing ... motion for a minimum of 15 seconds ... wash at least 2 inches above the wrist ... Rinse well ... Dry thoroughly with paper towels. Use a paper towel to turn off the faucet." 2. On 12/19/12 at 11:30 AM, Employee H, Registered Nurse, was observed to assess the oxygen saturation rate of patient #4 with a pulse oximeter and did not clean this equipment before or after using it on the patient. a. On 12/19/12 at 11:45 AM, Employee H indicated the pulse oximeter was to be disinfected before and after use on the patient. b. The agency policy titled "Infection Control" with a review date of 3/29/12 stated, "Surfaces and equipment shall be cleaned, then disinfected between patient contact."	G 121		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure care was provided as ordered on the plan of care or as required by agency policy in 1 of 10 records reviewed (Clinical record #10) with the potential to affect all patients of the agency.	G 158		

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G 158	Continued From page 4 Findings 1. Clinical record #10, start of care 10/17/12, included a plan of care with a certification period of 10/17/12 - 12/15/12, that identified the patient had a diagnosis of an open wound of the leg with complications. This plan of care evidenced the skilled nurse was to visit 1 time in week 1, 2 times in week 2, and once a week for 6 weeks with as needed visits for increase in wound drainage, dressing or wound problems, falls, or labs. However, the plan of care evidenced the skilled nurse to complete skin assessments; respiratory assessments including lung sounds; pedal pulse assessments; bilateral calf measurements for monitoring swelling in the lower legs; and the management of respiratory exacerbations; coughing deep / deep breathing exercises; use of spirometer; rest / activity schedule; oxygen and medication; pain medication schedule; identification of situations that exacerbate and relieve pain; the need for rest and balanced diet; alternative pain control such as relaxation, hot packs, imagery, distraction; and drug administration techniques. There was no order for 3 liters of oxygen per nasal cannula. The wound care noted was to cleanse daily with saline, apply silvadene to wound, cover with abdominal pads, and wrap with kerlix. a. The start of care assessment completed by Employee C, RN (Registered Nurse), 10/17/12 evidenced the patient had an open wound to the left leg and was on 3 liters of oxygen. The wound measured 7 cm (centimeter)long x 0.9 cm wide x 0.2 cm deep.	G 158		

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G 158	Continued From page 5 b. A "SN [skilled nurse] Progress Note" signed by Employee C on 10/22/12 evidenced a wound 3.5 cm long x .5 cm width X .2 cm deep. The nurse stated, "Patient refused to have wound care performed. He / she wanted to have the wound air out for awhile ... Wound care supplies brought for patient. Informed me that he won't be able to start antibiotic until his sister picks it up for him tomorrow. Left anterior leg wound healing well with minimal drainage, but surrounding skin ... very excoriated / reddened / weeping. Teaching provided on cellulitis and clindamycin used for treatment ... patient on 3 liters of oxygen with Saturation at 96 %. ... Condition [of the wound] indurated, separated, excoriated, reddened, weeping, moist irregular serosanguinous serous copious no odor ... surrounding tissue: red moist excoriated." The SN did not establish the pain medication schedule or identify situations that exacerbate and relieve pain, reinforce need for rest and balanced diet, or teach alternative pain control techniques such as relaxation, hot / cold packs, imagery, or distraction. c. A "SN [skilled nurse] Progress note" signed by Employee J, LPN (licensed practical nurse) on 10/25/12 stated, "Right [implied right leg wound] open to air. Patient says it is easier to keep it open to hair and have it drain onto towel than to keep rewrapping it. The skin on both lower extremities is very scaly. I encouraged him to apply silvadene to weeping areas daily. The color both lower extremities from the knee down are a dark reddish purple color from venous insufficiency. There are a multiple number of tiny closed blisters scattered all over the lower extremities especially the ankles and top of feet	G 158		

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G 158	Continued From page 6 ... I do not see any redness in the area that was treated for cellulitis." The document failed to evidence measurement of wounds including the wound in the left leg, blood pressure; teaching of blood pressure medications; teach lifestyle modifications including low sodium diet and regular exercise; pain management including establishing the pain medication schedule and teaching alternative pain control such as relaxation; hot / cold packs, imagery, and distraction. d. A "SN Progress note" signed by Employee C, RN, on 11/1/12 failed to evidence that a pain medication schedule was established; situations were identified that exacerbate and relieve pain were identified; need for rest and balanced diet were reinforced; alternative pain control such as relaxation, hot / cold packs, imagery, distraction were taught; and verbalization of the purpose of medications were not verbalized by the patient. The wound measured .2 cm length, 1.7 cm wide, and 0 cm depth. e. A "SN Progress note" signed by Employee J on 11/5/12 failed to evidence management of respiratory exacerbations including coughing / deep breathing exercises and management of oxygen and medication management was completed and that the patient could verbalize adequate relief of pain or cope with pain. The general notes stated, "Left lower leg had moderate amount of serous drainage. [He / she] allowed me to apply an abd [abdominal] pad to draining area. Area that is being treated for cellulitis is barely noticeable to me. The tissue of both lower extremities is a purplish discoloration from the venous stasis." The left leg wound	G 158		

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measured .5 cm. length. 4 cm. width, and 0 cm depth. The nurse also wrote, "Weeping wound noted from open area on old laceration." This new wound was not measured. The nurse had written that the goal of stable oxygenation level is not met and the patient was unable to maintain effective blood pressure management since the patient does not have a blood pressure machine.

f. A "SN Progress Note" signed by Employee C on 11/12/12 failed to evidence that management of respiratory exacerbations including coughing / deep breathing exercise were taught and the use of oxygen equipment was taught; pain medication schedule was established; situations were identified that exacerbate and relieve pain were identified; need for rest and balanced diet were reinforced; alternative pain control such as relaxation, hot / cold packs, imagery, distraction were taught; and verbalization of the purpose of medications were not verbalized by the patient.

g. A "SN Progress Note" signed by Employee J on 11/15/12 failed to evidence the nurse assessed vital signs; completed a respiratory assessment, taught the use of blood pressure medications; measured the patient's wounds; established a pain medication schedule; identified situations that exacerbated and relieved pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, distraction; or measured calves for edema.

h. A "SN Progress Note" signed by Employee J on 11/20/12 failed to evidence the nurse measured the wounds; taught the management

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of respiratory exacerbations, coughing / deep breathing exercise, rest / activity schedule, and oxygen and medication management; established a pain medication schedule; identified situations that exacerbate and relieve pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, and distractions; checked pedal pulses. The patient's goal of verbalized relief of pain was not met. The nurse stated under Endocrine system, "Symptoms - obesity - poorly controlled, is unable to exercise to reduce his weight."

i. A "SN Progress Note" signed by Employee C on 11/27/12 failed to evidence the nurse taught the management of respiratory exacerbations, coughing / deep breathing exercises, use of spirometer, rest / activity schedule/ oxygen and medication management; established a pain medication schedule; identified situations that exacerbated and relieved pain; reinforced the need for rest and balanced diet; and taught alternative pain control such as relaxation, hot / cold packs, imagery, distractions. The nurse wrote that relief of pain goals was not met.

2. The agency policy titled "Plan of care" with a review date of 3/29/12 stated, "A current written physician's plan of care shall be developed for each patient receiving care from the agency. Skilled nursing and home health aide services shall be in accordance with a plan based on the patient's diagnosis and assessment of the patient's immediate and long range needs and resources."

3. The agency policy titled "Acceptance of patients" with a review date of 3/29/12 stated,

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G 158	Continued From page 9 "The agency is dedicated to providing safe, quality services to those patients whose condition meets the qualifying criteria ... patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence ... Services must be based upon the patient's medical, nursing needs and / or request ... The patient and / or caregivers must indicate a commitment and willingness to cooperate with the treatment plan ... Medical care shall follow a written medical plan of care established and periodically reviewed by the physician." 4. The agency policy titled "Wound Care Protocol" with a review date of 3/29/12 stated, "It is the policy of the agency to incorporated nursing best practices for the benefit of the patient and for optimal wound healing. In coordination with the patient, physician, and wound clinic, the agency staff shall work toward an infection free and healed wound. Procedure: 1. Wounds shall be measured with the disposable wound measuring device and photographed on Mondays or the first visit of the week ... 3. Any deterioration in wound status is to be reported to the physician immediately." 5. On 12/20/12 at 3:40 PM, the administrator / director of nursing indicated that in clinical record #10 the skilled nurse did not follow the written plan of care.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and	G 159		

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equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

This STANDARD is not met as evidenced by:
Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the clinical records contained plans of care that included all of the required items in 3 of 10 (#3, #4, and #10) patient records reviewed creating the potential to affect all of the agency's patients.

Findings

1. Clinical record #3, start of care (SOC) 11/12/12, included a plan of care for the certification period of 11/12/12 - 1/10/13 that failed to evidence the patient had an oxygen concentrator and an order for oxygen at 4 liters per nasal cannula.

a. On 12/19/12 at 10 AM, patient #3 was observed to have an oxygen concentrator in the home and was on 4 liters of oxygen per nasal cannula. The patient had a CPAP (Continuous positive airway pressure) machine at the bedside.

b. On 12/19/12 at 10 AM, patient #3 indicated the CPAP machine was used at night.

c. On 12/21/12 at 2:10 PM, the administrator indicated there were no orders for the 4 liters of

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oxygen or the oxygen concentrator or the CPAP machine for nighttime use on the plan of care.

d. A "SN Progress Note" dated on 11/20/12 and signed by Employee H stated, "Discussed CPAP machine next to bed ... wears oxygen at all times at 4 liters per nasal cannula."

2. Clinical record #4, SOC 4/27/11, included a plan of care for the certification period of 12/17/12 - 2 /14/13 that failed to evidence the patient had a CPAP machine for use at night and a baclofen pump that had been surgically implanted on 10/18/12.

a. On 12/19/12 at 11:30 AM, patient #4 indicated the baclofen pump which had been surgically implanted on 10/18/12 was being used for medication administration and the CPAP machine was used while he / she slept.

b. On 12/19/12 at 11:30 AM, patient #4 was observed to have a CPAP machine at the bedside.

c. On 12/19/12 at 2:30 PM, the administrator indicated plan of care did not include the baclofen pump, the medication ordered with the baclofen pump, or the CPAP machine.

3. Clinical record #10, SOC 10/17/12, included a plan of care for the certification period of 10/17/12 - 12/15/12 that failed to evidence the patient had oxygen.

a. A clinical document titled "SN [skilled nurse] Progress note" signed by Employee C on 10/22/12 evidenced a wound 3.5 cm long x .5 cm

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G 159	Continued From page 12 width X .2 cm deep. The nurse stated, "Patient refused to have wound care performed. He / she wanted to have the wound air out for awhile ... patient on 3 liters of oxygen with Saturation at 96 %.." b. A clinical record document titled "SN [skilled nurse] progress note: 11/5/12" with a signature of Employee J, licensed practical nurse, stated, "Receiving oxygen ... oxygen per nasal cannula." c. On 12/20/12 at 3:30 PM, the administrator / director of nursing indicated the oxygen was not on the plan of care. 4. The agency policy titled "Plan of Care" with a review date of 3/29/12 stated, "A current written physician's plan of care shall be developed for each patient receiving care from the agency. ... Procedure 1. The plan of care shall include: all pertinent diagnosis ... mental status ... medications, treatments, and procedures."	G 159		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the skilled nurse provided as ordered on the plan of care in 1 of 10 records reviewed with the potential to affect all patients of the agency (See G 170), failed to ensure the registered nurse made revisions to the plan of care in 3 of 10 records reviewed with the potential to affect all patients of the agency (see G 173, and failed to ensure the licensed practical nurse	G 168		

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G 168	Continued From page 13 furnished services in accordance with agency policy for 1 of 10 records reviewed with the potential to affect all the patients of the agency who were cared for by a licensed practical nurse (see G 179. The cumulative effect of these systemic problems resulted in the agency's inability to be in compliance with the condition 42 CFR 484.30 Skilled Nursing Services.	G 168		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled nurse provided as ordered on the plan of care in 1 of 10 records reviewed (Clinical record #10) with the potential to affect all patients of the agency. Findings 1. Clinical record #10, start of care 10/17/12, included a plan of care with a certification period of 10/17/12 - 12/15/12, that identified the patient had a diagnosis of an open wound of the leg with complications. This plan of care evidenced the skilled nurse was to visit 1 time in week 1, 2 times in week 2, and once a week for 6 weeks with as needed visits for increase in wound drainage, dressing or wound problems, falls, or labs. However, the plan of care evidenced the skilled nurse to complete skin assessments; respiratory assessments including lung sounds; pedal pulse	G 170		

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assessments; bilateral calf measurements for monitoring swelling in the lower legs; and the management of respiratory exacerbations; coughing deep / deep breathing exercises; use of spirometer; rest / activity schedule; oxygen and medication; pain medication schedule; identification of situations that exacerbate and relieve pain; the need for rest and balanced diet; alternative pain control such as relaxation, hot packs, imagery, distraction; and drug administration techniques. There was no order for 3 liters of oxygen per nasal cannula. The wound care noted was to cleanse daily with saline, apply silvadene to wound, cover with abdominal pads, and wrap with kerlix.

a. The start of care assessment completed by Employee C, RN (Registered Nurse), 10/17/12 evidenced the patient had an open wound to the left leg and was on 3 liters of oxygen. The wound measured 7 cm (centimeter)long x 0.9 cm wide x 0.2 cm deep.

b. A "SN [skilled nurse] Progress Note" signed by Employee C on 10/22/12 evidenced a wound 3.5 cm long x .5 cm width X .2 cm deep. The nurse stated, "Patient refused to have wound care performed. He / she wanted to have the wound air out for awhile ... Wound care supplies brought for patient. Informed me that he won't be able to start antibiotic until his sister picks it up for him tomorrow. Left anterior leg wound healing well with minimal drainage, but surrounding skin ... very excoriated / reddened / weeping. Teaching provided on cellulitis and clindamycin used for treatment ... patient on 3 liters of oxygen with Saturation at 96 %. ... Condition [of the wound] indurated, separated, excoriated,

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reddened, weeping, moist irregular serosanguinous serous copious no odor ... surrounding tissue: red moist excoriated." The SN did not establish the pain medication schedule or identify situations that exacerbate and relieve pain, reinforce need for rest and balanced diet, or teach alternative pain control techniques such as relaxation, hot / cold packs, imagery, or distraction.

c. A "SN [skilled nurse] Progress note" signed by Employee J, LPN (licensed practical nurse) on 10/25/12 stated, "Right [implied right leg wound] open to air. Patient says it is easier to keep it open to hair and have it drain onto towel than to keep rewrapping it. The skin on both lower extremities is very scaly. I encouraged him to apply silvadene to weeping areas daily. The color both lower extremities from the knee down are a dark reddish purple color from venous insufficiency. There are a multiple number of tiny closed blisters scattered all over the lower extremities especially the ankles and top of feet ... I do not see any redness in the area that was treated for cellulitis." The document failed to evidence blood pressure; teaching of blood pressure medications; teach lifestyle modifications including low sodium diet and regular exercise; pain management including establishing the pain medication schedule and teaching alternative pain control such as relaxation; hot / cold packs, imagery, and distraction.

d. A "SN Progress note" signed by Employee C, RN, on 11/1/12 failed to evidence that a pain medication schedule was established; situations were identified that exacerbate and relieve pain

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were identified; need for rest and balanced diet were reinforced; alternative pain control such as relaxation, hot / cold packs, imagery, distraction were taught; and verbalization of the purpose of medications were not verbalized by the patient. The wound measured .2 cm length, 1.7 cm wide, and 0 cm depth.

e. A "SN Progress note" signed by Employee J on 11/5/12 failed to evidence management of respiratory exacerbations including coughing / deep breathing exercises and management of oxygen and medication management was completed and that the patient could verbalize adequate relief of pain or cope with pain. The general notes stated, "Left lower leg had moderate amount of serous drainage. [He / she] allowed me to apply an abd [abdominal] pad to draining area. Area that is being treated for cellulitis is barely noticeable to me. The tissue of both lower extremities is a purplish discoloration from the venous stasis." The left leg wound measured .5 cm. length. 4 cm. width, and 0 cm depth. The nurse also wrote, "Weeping wound noted from open area on old laceration." The nurse had written that the goal of stable oxygenation level is not met and the patient was unable to maintain effective blood pressure management since the patient does not have a blood pressure machine.

f. A "SN Progress Note" signed by Employee C on 11/12/12 failed to evidence that management of respiratory exacerbations including coughing / deep breathing exercise were taught and the use of oxygen equipment was taught; pain medication schedule was established; situations were identified that

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exacerbate and relieve pain were identified; need for rest and balanced diet were reinforced; alternative pain control such as relaxation, hot / cold packs, imagery, distraction were taught; and verbalization of the purpose of medications were not verbalized by the patient.

g. A "SN Progress Note" signed by Employee J on 11/15/12 failed to evidence the nurse assessed vital signs; completed a respiratory assessment, taught the use of blood pressure medications; measured the patient's wounds; established a pain medication schedule; identified situations that exacerbated and relieved pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, distraction; or measured calves for edema.

h. A "SN Progress Note" signed by Employee J on 11/20/12 failed to evidence the nurse measured the wounds; taught the management of respiratory exacerbations, coughing / deep breathing exercise, rest / activity schedule, and oxygen and medication management; established a pain medication schedule; identified situations that exacerbate and relieve pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, and distractions; checked pedal pulses. The patient's goal of verbalized relief of pain was not met. The nurse stated under Endocrine system, "Symptoms - obesity - poorly controlled, is unable to exercise to reduce his weight."

i. A "SN Progress Note" signed by Employee C on 11/27/12 failed to evidence the nurse taught the management of respiratory exacerbations,

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coughing / deep breathing exercises, use of spirometer, rest / activity schedule/ oxygen and medication management; established a pain medication schedule; identified situations that exacerbated and relieved pain; reinforced the need for rest and balanced diet; and taught alternative pain control such as relaxation, hot / cold packs, imagery, distractions. The nurse wrote that relief of pain goals was not met.

2. The agency policy titled "Plan of care" with a review date of 3/29/12 stated, "A current written physician's plan of care shall be developed for each patient receiving care from the agency. Skilled nursing and home health aide services shall be in accordance with a plan based on the patient's diagnosis and assessment of the patient's immediate and long range needs and resources."

3. The agency policy titled "Acceptance of patients" with a review date of 3/29/12 stated, "The agency is dedicated to providing safe, quality services to those patients whose condition meets the qualifying criteria ... patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence ... Services must be based upon the patient's medical, nursing needs and / or request ... The patient and / or caregivers must indicate a commitment and willingness to cooperate with the treatment plan ... Medical care shall follow a written medical plan of care established and periodically reviewed by the physician."

4. On 12/20/12 at 3:40 PM, the administrator /

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G 170	Continued From page 19 director of nursing indicated that in clinical record #10 the skilled nurse did not follow the written plan of care.	G 170		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the registered nurse made revisions to the plan of care in 3 of 10 records reviewed (Clinical record #3, 4, and 10) with the potential to affect all patients of the agency. Findings 1. Clinical record #3, start of care (SOC) 11/12/12, included a plan of care for the certification period of 11/12/12 - 1/10/13 that failed to evidence the registered nurse had revised the plan of care to include the patient had an oxygen concentrator and an order for oxygen at 4 liters per nasal cannula. a. On 12/19/12 at 10 AM, patient #3 was observed to have an oxygen concentrator in the home and was on 4 liters of oxygen per nasal cannula. The patient had a CPAP (Continuous positive airway pressure) machine at the bedside. b. On 12/19/12 at 10 AM, patient #3 indicated the CPAP machine was used at night. c. On 12/21/12 at 2:10 PM, the administrator	G 173		

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indicated there were no orders for the 4 liters of oxygen or the oxygen concentrator or the CPAP machine for nighttime use on the plan of care.

d. A "SN Progress Note" dated on 11/20/12 and signed by Employee H stated, "Discussed CPAP machine next to bed ... wears oxygen at all times at 4 liters per nasal cannula."

2. Clinical record #4, SOC 4/27/11, included a plan of care for the certification period of 12/17/12 - 2 /14/13 that failed to evidence the skilled nurse had revised the plan of care to include the patient had a CPAP machine for use at night and a baclofen pump that had been surgically implanted on 10/18/12.

a. On 12/19/12 at 11:30 AM, patient #4 indicated the baclofen pump which had been surgically implanted on 10/18/12 was being used for medication administration and the CPAP machine was used while he / she slept.

b. On 12/19/12 at 11:30 AM, patient #4 was observed to have a CPAP machine at the bedside.

c. On 12/19/12 at 2:30 PM, the administrator indicated plan of care did not include the baclofen pump, the medication ordered with the baclofen pump, or the CPAP machine.

3. Clinical record #10, SOC 10/17/12, included a plan of care for the certification period of 10/17/12 - 12/15/12 that failed to evidence the skilled nurse had revised the plan of care to include the patient had oxygen.

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G 173	Continued From page 21 a. A clinical document titled "SN [skilled nurse] Progress note" signed by Employee C on 10/22/12 evidenced a wound 3.5 cm long x .5 cm width X .2 cm deep. The nurse stated, "Patient refused to have wound care performed. He / she wanted to have the wound air out for awhile ... patient on 3 liters of oxygen with Saturation at 96 %.." b. A clinical record document titled "SN [skilled nurse] progress note: 11/5/12" with a signature of Employee J, licensed practical nurse, stated, "Receiving oxygen ... oxygen per nasal cannula." c. On 12/20/12 at 3:30 PM, the administrator / director of nursing indicated the oxygen was not on the plan of care. 4. The agency policy titled "Plan of Care" with a review date of 3/29/12 stated, "A current written physician's plan of care shall be developed for each patient receiving care from the agency. ... Procedure 1. The plan of care shall include: all pertinent diagnosis ... mental status ... medications, treatments, and procedures."	G 173		
G 179	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. This STANDARD is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure the licensed practical nurse furnished services in	G 179		

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accordance with agency policy for 1 of 10 records reviewed (clinical record #10) with the potential to affect all the patients of the agency who were cared for by a licensed practical nurse.

Findings

1. Clinical record #10, start of care 10/17/12, included a plan of care with a certification period of 10/17/12 - 12/15/12, that identified the patient had a diagnosis of an open wound of the leg with complications. This plan of care evidenced the skilled nurse was to visit 1 time in week 1, 2 times in week 2, and once a week for 6 weeks with as needed visits for increase in wound drainage, dressing or wound problems, falls, or labs. However, the plan of care evidenced the skilled nurse to complete skin assessments; respiratory assessments including lung sounds; pedal pulse assessments; bilateral calf measurements for monitoring swelling in the lower legs; and the management of respiratory exacerbations; coughing deep / deep breathing exercises; use of spirometer; rest / activity schedule; oxygen and medication; pain medication schedule; identification of situations that exacerbate and relieve pain; the need for rest and balanced diet; alternative pain control such as relaxation, hot packs, imagery, distraction; and drug administration techniques. There was no order for 3 liters of oxygen per nasal cannula. The wound care noted was to cleanse daily with saline, apply silvadene to wound, cover with abdominal pads, and wrap with kerlix.

a. A "SN [skilled nurse] Progress note" signed by Employee J, LPN (licensed practical nurse) on 10/25/12 stated, "Right [implied right

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leg wound] open to air. Patient says it is easier to keep it open to hair and have it drain onto towel than to keep rewrapping it. The skin on both lower extremities is very scaly. I encouraged him to apply silvadene to weeping areas daily. The color both lower extremities from the knee down are a dark reddish purple color from venous insufficiency. There are a multiple number of tiny closed blisters scattered all over the lower extremities especially the ankles and top of feet ... I do not see any redness in the area that was treated for cellulitis." The document failed to evidence measurement of wounds including the wound in the left leg, blood pressure; teaching of blood pressure medications; teach lifestyle modifications including low sodium diet and regular exercise; pain management including establishing the pain medication schedule and teaching alternative pain control such as relaxation; hot / cold packs, imagery, and distraction.

b. A "SN Progress note" signed by Employee J on 11/5/12 failed to evidence management of respiratory exacerbations including coughing / deep breathing exercises and management of oxygen and medication management was completed and that the patient could verbalize adequate relief of pain or cope with pain. The general notes stated, "Left lower leg had moderate amount of serous drainage. [He / she] allowed me to apply an abd [abdominal] pad to draining area. Area that is being treated for cellulitis is barely noticeable to me. The tissue of both lower extremities is a purplish discoloration from the venous stasis." The left leg wound measured .5 cm. length. 4 cm. width, and 0 cm depth. The nurse also wrote, "Weeping wound

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noted from open area on old laceration." This new wound was not measured. The nurse had written that the goal of stable oxygenation level is not met and the patient was unable to maintain effective blood pressure management since the patient does not have a blood pressure machine.

c. A "SN Progress Note" signed by Employee J on 11/15/12 failed to evidence the nurse assessed vital signs; completed a respiratory assessment, taught the use of blood pressure medications; measured the patient's wounds; established a pain medication schedule; identified situations that exacerbated and relieved pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, distraction; or measured calves for edema.

d. A "SN Progress Note" signed by Employee J on 11/20/12 failed to evidence the nurse measured the wounds; taught the management of respiratory exacerbations, coughing / deep breathing exercise, rest / activity schedule, and oxygen and medication management; established a pain medication schedule; identified situations that exacerbate and relieve pain; reinforced need for rest and balanced diet; taught alternative pain control such as relaxation, hot / cold packs, imagery, and distractions; checked pedal pulses. The patient's goal of verbalized relief of pain was not met. The nurse stated under Endocrine system, "Symptoms - obesity - poorly controlled, is unable to exercise to reduce his weight."

2. The agency policy titled "Plan of care" with a review date of 3/29/12 stated, "A current written physician's plan of care shall be developed for

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G 179	Continued From page 25 each patient reviving care from the agency. Skilled nursing and home health aide services shall be in accordance with a plan based on the patient's diagnosis and assessment of the patient's immediate and long range needs and resources." 3. The agency policy titled "Wound Care Protocol" with a review date of 3/29/12 stated, "It is the policy of the agency to incorporated nursing best practices for the benefit of the patient and for optimal wound healing. In coordination with the patient, physician, and wound clinic, the agency staff shall work toward an infection free and healed wound. Procedure: 1. Wounds shall be measured with the disposable wound measuring device and photographed on Mondays or the first visit of the week ... 3. Any deterioration in wound status is to be reported to the physician immediately." 4. On 12/20/12 at 3:40 PM, the administrator / director of nursing indicated the licensed practical nurse did not follow agency policy in clinical record #10.	G 179		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on policy review, clinical record review, home visit observation, and interview, it was determined the agency failed to ensure the registered nurse prepared complete, appropriate, and clear instructions for 4 of 5 records reviewed of patients with home health aide services observed at home visits with the potential to affect all of the patients receiving aide services	G 202		

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G 202	Continued From page 26 (See G 224) and failed to ensure the registered nurse assigned appropriate tasks to the home health aide for 1 of 5 patients observed at home visits with home health aide services with the potential to affect all of the patients receiving aide services (See G 225). The cumulative effect of these systemic problems resulted in the agency's inability to ensure home health aide care was provided as required by the Condition of Participation 484.36 Home Health Aide Services.	G 202		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on policy review, clinical record review, home visit observation, and interview, the agency failed to ensure the registered nurse prepared complete, appropriate, and clear instructions for 4 of 5 records reviewed of patients (#1,2, 3 and 4) with home health aide services observed at home visits with the potential to affect all of the patients receiving aide services. Findings include 1. On 12/18/12 at 8:15 PM, a home visit observation to patient #1 was made. Documentation in the home failed to include written instructions for Employee E, a home	G 224		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSOCIATED HOMECARE INC	2255 STURDY RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	Continued From page 27	G 224		

health aide (HHA).

a. On 12/18/12 at 8:15 PM, Employee E indicated she had not seen an aide care plan for months.

b. On 12/18/12 at 9:10 PM, Employee B, the alternate administrator, indicated there were no written instructions for the HHA in the patient's home.

2. On 12/19/12 at 7:30 AM, patient #2's home folder evidenced written patient care instructions dated 10/28/10 for the aide to remove a lidoderm patch at bedtime.

a. A clinical document from patient 2's record titled "Aide only" and dated on 12/1/12 and timed 7 PM - 9 PM and signed by Employee K, HHA stated, "Medication assistance." A clinical document from patient 2's record titled "Aide only" and dated on 12/12/12 and timed 7 PM - 9 PM and signed by Employee O, HHA, stated, "Medication assistance."

b. On 12/21/12 at 10:15 AM, Employee O indicated taking the lidoderm patch off patient #2 at the last visit she had made. Employee O indicated wearing gloves and throwing the patch into the trash. This was part of her duties under the medication assist on the aide care plan.

c. On 12/21/12 at 12 noon, Employee K, HHA, indicated taking the lidoderm patch off patient #2 in the past month while she made an evening visit to the patient. Employee K indicated wearing gloves while she took the lidoderm patch off the patient and then throwing the patch into

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the trash. This was a part of her duties under the medication assist on the aide care plan.

3. On 12/19/12 at 10:15 AM, a home visit observation to patient #3 was made. No documentation was found in the home that included written instructions for Employee G, HHA, who was present in the home and caring for patient #3.

On 12/19/12 at 10:15 AM, Employee G indicated she was not aware there were written aide instructions present in the home or home folder.

4. On 12/19/12 at 11:30 AM, a home visit observation to patient #4 was made. No documentation was found in the home that included written instructions for Employee F, HHA, who was present in the home and caring for patient #4.

a. On 12/19/12 at 11:30 AM, Employee F indicated not seeing aide care instructions for a couple of months.

b. On 12/19/12 at 2:30 PM, the director of nursing indicated the aide care plan needs to be available for the HHA to refer to while caring for the patient.

5. The agency policy titled "Home Health Aide: Assignment" with a review date of 3-2-12 stated, "A registered nurse shall make a home visit to assess the patient's needs prior to initiation of home health aide services. The registered nurse shall explain the duties of the home health aide and in consultation with the physician, patient,

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G 224	Continued From page 29 and / or caregivers determine the needs of the patient ... the evaluating nurse shall then complete a home health aide assignment sheet ... the home health aide assignment sheet shall be updated whenever a change in the orders or duties of the aide have been amended, but shall be updated and reviewed at least every 60 days." 6. The agency policy titled "Home Health aide: medication assistance" with a review date of 3/29/12 stated, "Home Health aide and personal care attendance may provide medication assistance to an individual who is unable to accomplish the task due to an impairment and who is either competent and has directed the services."	G 224		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review, interview, and policy review, the agency failed to ensure the medication profile included all the patient's medications for 1 of 12 records reviewed with the potential to affect all the agency's patients (File #4). Findings 1. Clinical #4, start of care 4/27/11, failed to evidence a medication profile had been updated	G 337		

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G 337	Continued From page 30 with a complete list of the patient's current medications. This was evidenced by the following: a. A clinical record document titled "SN [skilled nurse] Progress Note: 11/05/12" stated, "Spasms have decreased with the baclofen pump." b. On 12/19/12 at 11:30 AM, patient #4 indicated a baclofen pump was surgically implanted and the medication given through the pump was reducing his muscle spasms." c. A clinical document titled "Medications - Current" failed to evidence the Baclofen as a medication. d. On 12/19/12 at 2:30 PM, the administrator / director of nursing indicated the baclofen administered through the baclofen pump was not updated to the medication profile. 2. The agency policy titled "Medications" stated, "The primary nurse coordinating a patient's case shall be responsible for maintaining, updating and reviewing the patient's medication profile."	G 337		